The 'Capacity Planning and System Evaluation (CP&SE) Initiative' was established in October 2014 as one of four priority initiatives within the Rehabilitative Care Alliance's first mandate (April 2013-March 2015). The mandate of the CP&SE task and working groups was to develop a standardized toolkit to support the assessment of and planning for capacity of rehabilitative care services / programs and evaluation of rehabilitative care system performance. Their work has resulted in the development of two complementary frameworks – A Capacity Planning Framework and a System Evaluation Framework.

This Capacity Planning Framework outlines potential questions to be answered by a rehabilitative care system capacity planning process and potential measures and consideration within each sector of the rehabilitative care system that might help to answer those potential questions. The framework contains:

Introduction

This capacity planning framework has been developed to standardize the approach used by Health Service Providers (HSPs) and Local Health Integration Networks (LHINs) when undertaking capacity planning of rehabilitative care resources[1]. According to the Ontario Hospital Association's 'Position Statement on Funding and Capacity Planning for Ontario's Health System and Hospitals' (October 2011), capacity planning is a process for determining current and future health service requirements and is essential to guide strategic decisions regarding where investments need to be made and where shifts in funding are required. Capacity planning involves activities such as setting benchmarks for things like the number of hospital beds, long term care beds, assisted living spaces, home care hours, primary care services etc. that are necessary to meet the needs of the different populations using these services. Benchmarks should be guided by the best available evidence for determining appropriate utilization levels (OHA (2011) 'Position Statement on Funding and Capacity Planning for Ontario's Health System and Hospitals').

Aligned with the 'Ontario Stroke Networks Regional Economic Overviews', this capacity planning process has been developed to support LHINs and HSPs to identify "opportunities for improved care, potential for cost reductions relative to current expenditure and estimates of the need for re-investment or re-allocation of funding[2]" within local rehabilitative care systems and once completed, to form the foundation of a provincial rehabilitative care system capacity plan.

This process, in whole or in part, may be conducted on a general or population-specific basis depending on availability of information and specific, local needs. Capacity planning needs to look pragmatically at how best to provide optimal rehabilitative care to all patient populations given current capacity restrictions and the need to share this capacity amongst all populations requiring rehabilitation.[3] Analysis questions should be framed to meet local objectives prior to undertaking a capacity planning process i.e. only those questions/measures required to address local objectives/issues should be addressed to avoid excessive data burden.

The suggested measures/considerations within the framework are not intended to support planning of all beds within CCC or Acute Care where rehabilitative care is not the primary purpose/focus of care (i.e. Palliative Care, Respite, Behavioural programs as well as programs where patients are waiting for an alternate level of care). However, there is recognition that patients within these programs may receive some rehabilitative care for maintenance during their admission[4].

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[1] Rehabilitative Care
- It is delivered in homes, community based locations, long term care homes and hospitals.
- People may require rehabilitative care as a result of illness, injury, lifelong disability, chronic disease, or degenerative condition.
- It incorporates a broad range of interventions that address one or more of medical/clinical care needs, therapeutic needs, and/or psycho-social needs.
- The desired outcomes of rehabilitative care will include one or more of maintenance or sustaining of functionality[1], restoration of functionality and/or development of adaptive capacity

Note: This framework was not developed to support capacity planning of Pediatric or Mental Health Services.

[2] Meyer, M., McClure, A., O'Callaghan, C., Kelloway, L., Martin, C., Langstaff, K. (2013). Regional Economic Overview – South East LHIN. Ontario Stroke Network.

[3] Adapted from: Quality-Based Procedures: Clinical Handbook for Hip Fracture Health Quality Ontario & Ministry of Health and Long-Term Care (May 2013)

[4] RCA Definitions Framework for Bedded Levels of Rehabilitative Care (2014)

Considerations to Support Use of the RCA Capacity Planning Framework:

The framework is organized to first support an evaluation of the current state of rehabilitative care system resources around five dimensions: Population, Resources, Utilization, Access and Performance. It then supports definition of an ideal future state around the same five dimensions and in consideration of current and target performance and projected population needs (See Figure 1). Once the current state analysis and ideal future state design are complete, the framework suggests completion of a gap analysis between the current & desired future states. This gap analysis will reveal the changes that are required to realize the desired future state and will support the development of an action plan and action plan risk assessment.

1. The first step is to define the scope of your capacity plan i.e. What rehabilitative care populations are included? What geographical area is being included in the plan? What sectors, programs and services are included?
2. Next, identify which of the high level "Questions Suggested to Be Answered by Capacity Planning Process" (in the left hand column) within each domain are relevant to the needs/objectives of your capacity plan. Consider additional questions that may be specific to your regional needs/context.
3. Finally, select the corresponding "Potential Measures/Considerations" (organized by sector - Acute Care, Bedded Rehabilitative Care, Community/ Ambulatory, Bedded or Community Long Stay) that will support the development of answers to the identified questions.

Other Considerations:

- The category 'Bedded Rehabilitative Care' is included with the intention that these resources be aligned with the categorizations described within the RCA Definitions Framework[5]
- The RCA Definitions Framework for Community Levels of Care[6] should be accessed to support the analysis within the Community/ Ambulatory sector. Additionally, once implemented, the RCA Outpatient/Ambulatory Minimum Data Set[7] may help to inform the analysis within the Community/ Ambulatory sector.
- In order to quantify expected capacity needs, it is most ideal to have the lowest/most detailed level of data available i.e. patient level should be used where available and where not, the lowest most detailed level data from that data base should be used[8].
- Recognizing the challenges that exist with respect to incongruent definitions across sectors/databases (e.g. patient classifications/diagnostic descriptors, discharge destinations etc.), significant effort is required to ensure that an individual episode of care [9]can only be categorized into a single condition/population to prevent double counting

[5] RCA Definitions Framework for Bedded Levels of Rehabilitative Care (2014)
[6] RCA Definitions Framework for Community Levels of Care (2014)
[7] RCA OP/AMB Minimum Data Set (2015)
[8] Optimus SBR. Capacity Planning and System Evaluation Initiative Response to Invitation to Comment November 7, 2014
[9] Episode of Care: One discrete group of condition/diagnosis specific, time-limited, goal-oriented therapy services provided to a specific patient and must involve an assessment, and/or treatment (according to a set plan with treatment goals), and discharge (including reporting on specific outcome measures). A patient can receive more than one episode of care in a year provided that all eligibility criteria, including a separate referral, are met for each individual episode of care. The block therapy model for a patient with a specific medical condition is considered one episode of care. Calculation of Episode of Care Days: Date of first treatment appointment session to date of completion or discontinuation of outpatient rehab from all health professions inclusive of any follow-up visits up to one month post the last treatment appointment. Adapted from: Physiotherapy Provider Qs & As, Publicly Funded Clinic Based Physiotherapy Services, Ministry of Health and Long-Term Care. October, 2013

- In addition to including ALC rates in the current state analyses, consider a more detailed analysis of these ALC rates to develop an understanding of unmet need versus needs met in an untimely manner.
- Bolded "Potential Measures/Considerations" are those considered to be essential for completion by all LHINs/regions completing rehabilitative care system capacity plans. Doing so will support the development of a common language and foundational understanding of provincial rehabilitative care system resources and could potentially be used to inform the development of a provincial rehabilitative care system capacity plan in the future.

Figure 1 – Rehabilitative Care Alliance Capacity Planning Framework

		Questions To Be Answered by Capacity Planning Process	Potential Measures/Considerations			
			Acute Care	Bedded Rehabilitative Care	Community/ Ambulatory	Bedded or Community Long Stay
Current State	Population					
	Resources					
	Utilization					
	Access					
	Effectiveness					
Complete Evaluation of Current State						
Future State	Population					
	Resources					
	Utilization					
	Access					
	Effectiveness					
Redesign						

Questions Suggested To Be Answered by Capacity Planning Process		Suggested Measures/Considerations Consider reporting indicators in this column both generally and/or by population, where data is available			
		A. Acute Care	B. Bedded Levels of Rehabilitative Care (i.e. Short Term Complex Medical Management, Rehabilitation, Activation/Restoration)	C. Community/Ambulatory	D. Bedded or Community Long Stay (Note: Data by diagnostic group is currently not available through the Resident Assessment Instrument – Minimum Data Set 2.0 (RAI-MDS 2.0))
Current State					
Population	• What discharge destinations (e.g. home, bedded levels of rehabilitative care, LTC etc.) are patients with restorative potential referred to from acute care? • What rehabilitative care services (e.g. out-patient rehabilitative care, CCAC rehabilitative care, community services etc.) are patients with restorative potential referred to from acute care? • What discharge destinations (e.g. home, bedded levels of rehabilitative care, LTC etc.) are patients with restorative potential referred to from bedded levels of rehabilitative care? • What rehabilitative care services (e.g. out-patient rehabilitative care, CCAC rehabilitative care, community services etc.) are patients with restorative potential referred to from bedded levels of rehabilitative care? • What populations are currently receiving bedded and community based rehabilitative care services (as described in the RCA Definitions Framework)? • What rehabilitative care services are provided in	• **Annual prevalence/incidence by condition/population**[10] • **Where evidence exists, incidence of rehab need by condition (e.g. number of stroke patients that are known to require each level of rehabilitative care based on stroke severity compared to actual numbers of patients served)** • Current trajectory of care			
		• Annual # of acute care admissions for conditions typically requiring rehabilitative care* • Average/mean age of patients referred to each level of rehabilitative care/service per year • Percent of patients >65 years of age referred to each rehabilitative care level of care/service per year	• **Utilization Rates – Rehabilitative Care Cases/100,000** • Socio-demographics of current rehab service recipients by population (e.g. hip fracture, stroke etc.) • **Average/mean age of patients admitted to each level of rehabilitative care/service per year** • Percent of patients >65 years of age admitted to each rehabilitative care level of care/service per year • **Percentage of patients admitted to each level of rehabilitative care/service from outside of catchment area (LHIN Catchment Area).** • **Description/profile of patients accessing rehabilitative care services outside of LHIN and the services they are accessing.**		

[10] Consider using http://www.publichealthontario.ca/en/DataAndAnalytics/Snapshots/Pages/Chronic-Disease-Hospitalization.aspx

Questions Suggested To Be Answered by Capacity Planning Process		**Suggested Measures/Considerations** Consider reporting indicators in this column both generally and/or by population, where data is available			
		A. Acute Care	B. Bedded Levels of Rehabilitative Care (i.e. Short Term Complex Medical Management, Rehabilitation, Activation/Restoration)	C. Community/Ambulatory	D. Bedded or Community Long Stay (Note: Data by diagnostic group is currently not available through the Resident Assessment Instrument – Minimum Data Set 2.0 (RAI-MDS 2.0))
	acute care (e.g. Rehab FTE/ Acute Care Beds etc.)? • What rehabilitative care services are being accessed outside of your region/LHIN? • Which populations are accessing these services and why? • What populations are currently not being served?	* Refer to literature that indicates populations who benefit from rehabilitative care, RM&R Data and/or ALC data that indicates populations experiencing difficulty with access, patient stories/interviews etc. Also refer to Appendix 1 - QBP Handbook Cohort Definition and Patient Grouping Approach for definitions of QBP populations. In order to identify populations that are not being served, may also consider comparing across LHINs or Sub-LHIN regions. If like groups of people have different incidence of care, the difference may point to under or over-serving[6]			
Appropriately Resourced	• What rehabilitative care system resources are currently available, including: ▪ HR – Allied ▪ HR – Medical ▪ Financial	• # of Physiatrist per 100,000 (per LHIN) and their geographical distribution in the region • # of Geriatricians per 100,000 (per LHIN) and their geographical distribution in the region • # of Allied Health Professionals (PT/OT/SLP/RN) per 100,000 (per LHIN) and their geographical distribution in the region • Configuration of rehabilitative care beds - number of sites, programs offered at each site etc.			
		• **PT/OT/SLP/ Nursing[11] etc. to bed ratios** • **PT/OT/ SLP/Nursing[5] etc. to patient ratios** • Average therapy minutes received /bed/week in each level of care	• **PT/OT/SLP/Nursing[5] etc. to bed ratios** • **PT/OT/SLP/Nursing[5] etc. to patient ratios** • Beds per rehabilitation candidate (Ideal if data available) OR Beds to incident population OR **Beds per 100,000** • Beds per 100,000 residents that are 75+ • **Medical model of care e.g. # of planned weekly visits** • **Average therapy minutes received /bed/week in each level of care** • Intensity of services provided in each level of care (RIW, RUG)	• Location of programs/services (OP/Ambulatory/Community) • **FTE/volume of patients (OP)** • Number of contracted home care **PT/OT/SLP/Nursing[5]** allied FTE per capita (In home) • **Community Physiotherapy Clinics - volumes, FTE, wait list, patient profiles/diagnosis**	CCC • **PT/OT/ SLP/Nursing[5] etc. to bed/patient ratios** LTCH • Number and hours of PT/OT/SLP/Nursing Full-Time-Equivalent (FTE) per bed and their support staff (including all purchased services) • Intensity of rehabilitative care services being provided (as per MDS RUG designations)

[11] Depending on specific population and needs, additional Health Human Resources/Interdisciplinary Health Professional may be required.

Questions Suggested To Be Answered by Capacity Planning Process		Suggested Measures/Considerations Consider reporting indicators in this column both generally and/or by population, where data is available			
		A. Acute Care	B. Bedded Levels of Rehabilitative Care (i.e. Short Term Complex Medical Management, Rehabilitation, Activation/Restoration)	C. Community/Ambulatory	D. Bedded or Community Long Stay (Note: Data by diagnostic group is currently not available through the Resident Assessment Instrument – Minimum Data Set 2.0 (RAI-MDS 2.0))
Efficiency	How are existing rehabilitative care system resources being utilized?	**Average # of patients repatriated to acute care from each level of rehabilitative care per month**	• **# of patients served within each level of rehabilitative care** • **Profile of patients served within each level of care:** – **Place of residence (i.e LTC, Community, etc)** – **Admission source to each level of rehabilitative care** – **Average admission FIM score** – **Average # of reported/recorded health conditions/comorbidities** – **Discharge disposition/ destination** • **Average # of patients transferred to acute care from each level of care per month** • Average # of ED visits from each level of care per month • **Occupancy rates within each level of rehabilitative care** • **Bed Equivalents based on 95% occupancy for each level of care** • **LHIN/organization-level ALC rates by destination within each level of rehabilitative care** • **Average FIM Efficiency**	**In-home Care** • **Services delivered by condition/ diagnosis:** – **# who received nursing and # of visits per case** – **# who received PT and number of visits per case** – **# who received SW and number of visits per case** – **# who received SLP and number of visits per case** – **# who received personal support services and number of hours per case** – **# who received OT and number of visits per case** – Allied health home care hours/costs per unit of service – Cost to deliver service (patient vs. program) **OP/AMB** • See Rehabilitative Care Alliance Outpatient/Ambulatory Minimum Data Set (www.rehabcarealliance.ca)	**CCC** • **Occupancy rates within each level of rehabilitative care** • **LHIN/organization-level ALC rates by destination within each level of rehabilitative care** **LTCH** • **Average number of physiotherapy minutes per resident** **CCC & LTCH** • Direct and indirect costs to deliver service per patient/resident • Proportion of patients receiving rehabilitative care services

Questions Suggested To Be Answered by Capacity Planning Process	Suggested Measures/Considerations Consider reporting indicators in this column both generally and/or by population, where data is available			
	A. Acute Care	B. Bedded Levels of Rehabilitative Care (i.e. Short Term Complex Medical Management, Rehabilitation, Activation/Restoration)	C. Community/Ambulatory	D. Bedded or Community Long Stay (Note: Data by diagnostic group is currently not available through the Resident Assessment Instrument – Minimum Data Set 2.0 (RAI-MDS 2.0))
		• Direct and indirect costs for service by weighted case • Actual Cost vs. Expected Cost	**OP/AMB & In-home Care** • Source of referrals • # of visits/attendances (average/median) per health profession functional centre for all health profession functional centres received by each patient within the episode of care – # who received physiotherapy, average total number of PT minutes per episode of care – # who received social work and average total number of SW minutes per episode of care – # who received SLP, average total number of SLP minutes per episode of care – # who received OT average total number of SLP minutes per episode of care – # who received nursing, average total number of nursing minutes per episode of care. – Average length of each episode of care – Average total cost for an episode of care to treat each patient by patient population/diagnosis group • Total # of minutes being provided to patients per episode of care	

Questions Suggested To Be Answered by Capacity Planning Process		Suggested Measures/Considerations Consider reporting indicators in this column both generally and/or by population, where data is available			
		A. Acute Care	B. Bedded Levels of Rehabilitative Care (i.e. Short Term Complex Medical Management, Rehabilitation, Activation/Restoration)	C. Community/Ambulatory	D. Bedded or Community Long Stay (Note: Data by diagnostic group is currently not available through the Resident Assessment Instrument – Minimum Data Set 2.0 (RAI-MDS 2.0))
Access	▪ What rehabilitative care services are available for specific population groups (e.g. stroke, total joint, fractured hip, pulmonary etc.)? ▪ Are services available to meet the rehabilitative care needs of all populations? ▪ What populations are waiting for bedded levels of rehabilitative care? ▪ Are specialized/regional rehabilitative care programs accessible in a timely manner? How long are patients waiting to access specialized/ regional rehabilitative care programs? Where are they waiting? ▪ Does critical mass exist (according to available evidence or geographical context, or related to the goals of capacity planning)? If not, could services be restructured to create critical mass within or across LHINs? If critical mass does not exist locally, is access to regional/provincial programs available? ▪ Is there equitable access to services across the region/province? ▪ What transportation options are available to support patients to access services? ▪ Do volumes exist (by population) to support a local service? If not, is there timely, streamlined access to regional services?		• **Rates & reasons for denial** • **Average travel time/distance of service from home of patient (by postal code)** • **Source of rehabilitative care referrals/admission disposition** • **Acute ALC rates to each level of rehabilitative care**		

Questions Suggested To Be Answered by Capacity Planning Process	Suggested Measures/Considerations Consider reporting indicators in this column both generally and/or by population, where data is available			
	A. Acute Care	B. Bedded Levels of Rehabilitative Care (i.e. Short Term Complex Medical Management, Rehabilitation, Activation/Restoration)	C. Community/Ambulatory	D. Bedded or Community Long Stay (Note: Data by diagnostic group is currently not available through the Resident Assessment Instrument – Minimum Data Set 2.0 (RAI-MDS 2.0))
	• **ALC rates from acute to each level of rehabilitative care.**	• Comparison of admission/discharge criteria across sites, programs and/or populations • **Population distribution relative to service availability** e.g. – Proximity of beds across the region by the patient population – Services matched to patient need (e.g. designation under French Language Services Act) • Referral patterns/processes e.g. – % / diagnosis of patients referred to a bedded level of rehabilitative care – Referral response times • **Correlation of ALC to occupancy** (i.e. process versus access issues?) • **Describe transportation options (public and accessible) that are available to support family/caregivers to attend/visit**	• **OP/Amb - Wait times to access** • **OP/Amb – Reason for wait (i.e. operational versus supply/demand pressures)** • **OP/Amb - Population distribution relative to service availability** • Referral patterns/processes e.g. – Percent/Number of patients, by diagnosis referred for in home rehabilitative care and associated referral response times – Time from referral to first rehabilitative care service, by discipline • Describe transportation options (public and accessible) that are available to support patients/caregivers to access services • **Duration and frequency of Ministry exercise/falls prevention classes, number of participants.**	• **Describe transportation options (public and accessible) that are available to support family/caregivers to attend/visit** • **LTCH - Duration and frequency of exercise classes, number of participants.** • **LTCH - Duration and frequency of falls prevention classes, number of participants.**

Questions Suggested To Be Answered by Capacity Planning Process		Suggested Measures/Considerations Consider reporting indicators in this column both generally and/or by population, where data is available			
		A. Acute Care	B. Bedded Levels of Rehabilitative Care (i.e. Short Term Complex Medical Management, Rehabilitation, Activation/Restoration)	C. Community/Ambulatory	D. Bedded or Community Long Stay (Note: Data by diagnostic group is currently not available through the Resident Assessment Instrument – Minimum Data Set 2.0 (RAI-MDS 2.0))
Effectiveness	▪ What is current performance?	**Contribution of each rehabilitative care program/service to other system services (e.g. flow, care integration etc.)** **Patient Outcomes**			
		• **Actual vs. Expected acute LOS for conditions typically requiring rehabilitative care*** • Rate of readmission to acute care within 30 days of discharge from acute care (for conditions that are expected to require post-acute rehabilitative care)	**Patient Outcomes to be Considered Within NRS include:** • **Average change in FIM score** • **Average LOS within each level of care (as compared to ELOS)** • **Distribution of LOS by RPG** • **Patient Days/Year by RPG** • **Discharge disposition from each level of care** • **% discharged with service goals met** • **Rate of readmission to acute care within 30 days of discharge from bedded level of rehabilitative care** (Note: Not NRS Service Interruption definition)	Distribution of LOS within each episode of care by age /program/diagnosis	**CCC** • **Average LOS within each rehabilitative care program** • **Distribution of LOS within each rehabilitative care program by age/ program/diagnosis**
		*Refer to literature that indicates populations who benefit from rehabilitative care, RM&R Data and/or ALC data etc. that indicates populations experiencing difficulty with access, patient stories/interviews etc. Also refer to Appendix 1 - QBP Handbook Cohort Definition and Patient Grouping Approach for definitions of QBP populations.			
		Complete Current State Analysis - TBD by LHINs as appropriate NOTE: Refer to current performance on RCA's Rehabilitative Care System Evaluation Framework to guide/inform gap analysis			

Questions Suggested To Be Answered by Capacity Planning Process		Potential Measures/Considerations			
		Acute Care	Bedded Levels of Rehabilitative Care (i.e. Short Term Complex Medical Management, Rehabilitation, Activation/Restoration)	Community/Ambulatory	Bedded or Community Long Stay
FUTURE STATE					
Population	What are the characteristics of the populations that are projected to require rehabilitative care services?	**Population projections** including growth, disease projections, risk factors[12], changes in eligibility criteria unmet needs adjustment[13] etc. and the expected impact on rehabilitative care system utilization Population-level incidence & prevalence rates Demographic analysis of current pediatric rehabilitative care populations that are expected to transition to the adult system for the period of time covered by the capacity plan. Best practices/trends Expected/Anticipated changes in health care service organization/provision (e.g. HSPs expected to increase / decrease service capacity) Description of desired/ideal trajectory of care			
Appropriately Resourced	▪ Are there sufficient rehabilitative care services as per provincial standardized definitions? ▪ Are existing services appropriately resourced to offer best practice? ▪ Could the program/service be offered in a more cost efficient setting without affecting outcomes? ▪ What are anticipated impacts of funding/policy changes?		Optimize alignment of resources / services within provincial directions (e.g. RCA Definitions Framework, Assess and Restore Guideline etc.). For example: • Arrangement of services within alignment RCA Definitions Framework • Determine the optimal resource mix and capacity requirements for delivering A&R within their boundaries, with the goal of providing the most appropriate interventions in the most cost-effective manner possible • Are there plans to adopt “System Beds” and/or Coordinated Access?		
		Based on available best practice literature, provincial indicators and targets, where they exists, , anticipated need and/or current performance describe the ideal future state with respect to:			

[12] Environmental scan encompassing lifestyle factors that may increase the susceptibility of residents of this LHIN to future healthcare system usage (SW LHIN Complex Continuing Care & Rehabilitation Re-designation Initiative, 2012)
[13] Unmet needs adjustment to be determined based on local needs. This adjustment may include 1) the average number of individuals ALC to (bedded levels under review) over a 24 month trend, 2) # of individuals waiting > 5 days for access, 3) expected changes to eligibility criteria etc.

Questions Suggested To Be Answered by Capacity Planning Process	Potential Measures/Considerations			
	Acute Care	Bedded Levels of Rehabilitative Care (i.e. Short Term Complex Medical Management, Rehabilitation, Activation/Restoration)	Community/Ambulatory	Bedded or Community Long Stay
FUTURE STATE				
	▪ PT/OT/Therapy Assistant/SLP/Nursing etc. to patient/bed ratios as per provincial definitions framework and best practices ▪ Bed to population ratios (e.g. beds per 100,000)	▪ PT/OT/Therapy Assistant /SLP/Nursing etc. to patient/bed ratios as per provincial definitions framework and best practices ▪ Bed to population ratios (e.g. beds per 100,000) ▪ Medical model of care (i.e. # of planned weekly visits)	▪ Number/location of outpatient/ambulatory services ▪ Number of contracted home care allied FTE per capita	▪ CCC - PT/OT/TA/SLP/Nursing etc. to bed/ patient ratios ▪ LTCH –Number and hours of Physiotherapist Full-Time-Equivalent (FTE) and their support staff (including all purchased services)

Questions Suggested To Be Answered by Capacity Planning Process		Potential Measures/Considerations			
		Acute Care	Bedded Levels of Rehabilitative Care (i.e. Short Term Complex Medical Management, Rehabilitation, Activation/Restoration)	Community/Ambulatory	Bedded or Community Long Stay
FUTURE STATE					
Efficiency	• What level of utilization is required to achieve target outcomes? (E.g. as per RCA Evaluative Framework and/or other provincial targets)? • Are existing resources being optimally utilized? • Are patients able to access rehabilitative care in the most appropriate/cost effective setting? (E.g. Are patients being referred for in-home rehabilitative care who might otherwise be served in outpatient/ambulatory rehabilitative care settings if those services were available) • Are there: – Alternate / innovative service delivery models and/or settings that would maximize resource efficiency? (e.g. healthcare-recreation partnerships, fitness centres, community based exercise classes, etc.) – Opportunities for new/enhanced programs? – Opportunities for consolidation/specialization of programs? – Opportunities to support a shift from acute to community care? • Are scopes of practice being maximized? E.g. advanced practice, Nurse Practitioners etc.?	Consider alternate/innovative service delivery model/settings Consider opportunities for standardization, automation, computerization and forcing functions maximize efficiency/utilization Examples of Tests of Efficiency: • Drill down on ALC - Compare ALC Rates against Occupancy Rates. If high ALC and high occupancy, consider a capacity issue. If high ALC and low occupancy, consider a referral process/access issue.			

Questions Suggested To Be Answered by Capacity Planning Process		Potential Measures/Considerations			
		Acute Care	Bedded Levels of Rehabilitative Care (i.e. Short Term Complex Medical Management, Rehabilitation, Activation/Restoration)	Community/Ambulatory	Bedded or Community Long Stay
		Based on available best practice literature, provincial indicators and targets, where they exist , anticipated need and/or current performance describe the ideal future state with respect to:			
		• Length of stay/ELOS • ALC rates to each level of Rehabilitative care • Market analysis and ideal market share	• Length of stay/ELOS by RPG • Volume of patients served within each level of care • Occupancy rates within each level of care • ALC rates within each level of care • Market analysis and ideal market share	• Allied health home care hours/ costs per unit of service • Allied health outpatient hours/ costs per unit of service	**CCC** • Average length of stay • Occupancy within each rehabilitative care program in CCC • ALC rates within each rehabilitative care program in CCC **LTCH** • Duration and frequency of classes, number of participants **CCC & LTCH** • Proportion of patients/residents receiving rehabilitative care services • Number of Physiotherapy minutes per patient/resident • Intensity of rehabilitative care
Access	• Does critical mass exist? If not, could services be restructured to create critical mass within or across LHINs? Is access to regional/provincial programs available? NOTE: In the absence of best practice evidence to define critical mass, operational efficacy could be used to determine critical mass locally.	Describe ideal transportation options (public and accessible) required to support patients/caregivers to access services Describe a streamlined process to support patients with functional progression or maintenance goals who are transitioning from an acute or formal rehabilitative care setting to a community-based setting who are transitioning across the rehabilitative care system			
			• In consideration of 'Reasons for Denial', what additional services are required to support access for populations currently not being served? • In consideration of current average travel time/distance of service from home of patient (by postal code), what additional resources/services are required to support equitable service distance for residents of the region?		

Questions Suggested To Be Answered by Capacity Planning Process		Potential Measures/Considerations			
		Acute Care	Bedded Levels of Rehabilitative Care (i.e. Short Term Complex Medical Management, Rehabilitation, Activation/Restoration)	Community/Ambulatory	Bedded or Community Long Stay
	• Are services available to meet the rehabilitative care needs of all populations? (including cross LHIN referrals) • Is there equitable access to services across the region/province? • Are adequate transportation options available to support patients to access services? • Are there local and/or regional issues/principles/policy to be considered?	Based on available best practice literature, provincial indicators and targets, where they exists, anticipated need and/or current performance describe the ideal future state with respect to: • Required critical mass as per best practice • Acute ALC rates to rehab / CCC • Streamlined referral patterns/processes to other levels of rehabilitative care	• Required critical mass as per best practice • Wait times to regional programs, where critical mass does not exist • Equalized service availability (i.e. distance from home) relative to population distribution • Streamlined referral patterns/processes to other levels of rehabilitative care	• Required critical mass as per best practice • Wait times • Equalized service availability (i.e. distance from home) relative to population distribution • Streamlined referral patterns/processes to other levels of rehabilitative care	
		Based on available best practice literature, provincial indicators and targets (where they exist), anticipated need and/or current performance describe the ideal future state with respect to:			
Effectiveness	• What is current performance relative to current and projected target performance and best practice patient outcomes? • Does the future-state care delivery model align with LHIN priorities within the IHSP? • Are existing programs /services effective?	• Patient outcomes (e.g. patient disposition from acute care for all rehab populations, readmissions rates, patient experience). • Cost to deliver service • Support to other system services	• Patient outcomes (e.g. patient disposition for all populations including those designated ALC, readmission rates, patient experience). • Cost to deliver service • Support to other system services	• Patient outcomes (e.g. patient disposition for all populations including those designated ALC, readmission rates, patient experience). • Cost to deliver service • Support to other system services	• Patient outcomes (e.g. patient disposition all of the rehab populations including those designated ALC, patient experience). • Cost to deliver service • Support to other system services

Questions Suggested To Be Answered by Capacity Planning Process	Potential Measures/Considerations			
	Acute Care	Bedded Levels of Rehabilitative Care (i.e. Short Term Complex Medical Management, Rehabilitation, Activation/Restoration)	Community/Ambulatory	Bedded or Community Long Stay
Redesign - TBD by LHINs as appropriate	▪ Complete a gap analysis between current & desired future states ▪ Describe the changes that should be made to the system based on the results of the capacity planning process ▪ Develop an Action Plan, Action Plan Risk Assessment (based on the assumptions that have been made to inform the current and future state design) and a Risk Mitigation Plan to support realization of the defined future state NOTE: If this Action Plan involves the potential re-classification of CCC to inpatient rehab beds, refer to the Rehabilitative Care Alliance 'Planning Considerations for Re-Classification of CCC/Rehab Beds Toolkit'			

Appendix A – List of Consultant Feedback and LHIN Rehab Reports That Were Reviewed and Incorporated into the RCA Capacity Planning Framework

Consultant Feedback

1. Optimus SBR
2. Deloitte Inc.

LHIN Rehab Reports

- North Simcoe Muskoka Review of Rehabilitative Care – 2014
- HNHB LHIN Restorative Care Bed Review: Final Report and Recommendations 2013
- NE LHIN Rehabilitation (Rehab) and Complex Continuing Care (CCC) Systems Review 2012
- SW LHIN Complex Continuing Care & Rehabilitation Re-Alignment Initiative 2012
- Implementing Stroke and Orthopaedic Best Practices in the Toronto Central LHIN – Analysis of System Wide Impacts 2012
- Rehabilitation System Strategic Plan for the Erie St. Clair Region - 2012
- Central LHIN Hospitals ALC Rehab Steering Committee – Phase One Report – Orthopedics 2012
- WWLHIN Rehabilitation Services Review – 2012
- HNHB LHIN: An Integrated Program for Complex Care in the HNHB 2010
- Smoother Transitions, Better Outcomes – Building a Framework to Rethink Rehab Central West LHIN 2010
- Rehabilitation is a Journey – Central East LHIN 2009
- Mississauga Halton LHIN – Transitional Services Program Strategic Directions 2009
- Regional Review of Rehabilitation Services in the Champlain Local Health Integration Network 2007

APPENDIX B – QBP Handbook Cohort Definition and Patient Grouping Approach (As of March 26, 2015)
NOTE 1: Consider new QBPs introduced by HQO after the stated publication date
NOTE 2: QBP cohorts are not always consistent with full diagnostic cohort. For planning purposes, consideration should be given to ensure sufficient capacity for full diagnostic cohort.

Type			ICD-10 /CCI CODE
Stroke[14,15]	TIA		G45 (excluding G45.4)
	ICH		I61
	Ischemic		I63 (excluding I63.6), H34.1
	Unable to Determine		I64
Hip Fracture[16]	Fracture of neck of femur		S72.0
	Pertrochanteric fracture		S72.1
	Subtrochanteric fracture		S72.2
COPD[17,18]	Mild exacerbation	Patient treated in the ED or in outpatient settings and discharged home without requiring an inpatient admission	ICD-10-CA codes J41-J44, with the exception of panlobular emphysema (J43.1), centrilobular emphysema (J43.2), and Macleod syndrome (J43.0)
	Moderate exacerbation	Patient requires admission to inpatient care	
	Severe exacerbation	Patient requires ventilation (either non-invasive or invasive ventilation) and/or admission to an intensive care unit.	
CHF[19,20]	Heart failure		I50
	Congestive heart failure		I50.0
	Left ventricular failure		I50.1
	Heart failure, unspecified		I50.9
	Myocarditis		I40.x, I41.x
	Ischemic cardiomyopathy		I25.5
	Cardiomyopathies		I42.x, I43.x
	Hypertensive heart disease plus heart failure, left ventricular dysfunction		I11.x plus I50.x (secondary diagnosis)
	Hypertensive heart disease and renal disease plus heart failure, left ventricular dysfunction		I13.x plus I50.x (secondary diagnosis)

[14] Quality-Based Procedures: Clinical Handbook for Stroke. March 2013 (Updated September 2013); pp. 1-59
[15] Health Quality Ontario; Ministry of Health and Long-Term Care. Quality-based procedures: clinical handbook for stroke (acute and postacute). Toronto: Health Quality Ontario; 2015 February. 148 p. Available from: http://www.hqontario.ca/evidence/evidence-process/episodes-of-care#community-stroke.
[16] Quality-Based Procedures: Clinical Handbook for Hip Fracture. May 2013; pp. 1–97
[17] Quality-Based Procedures: Clinical Handbook for Chronic Obstructive Pulmonary Disease. Health Quality Ontario & Ministry of Health and Long-Term Care. January 2013
[18] Health Quality Ontario; Ministry of Health and Long-Term Care. Quality-based procedures: Clinical handbook for chronic obstructive pulmonary disease (acute and poastacute). February 2015. 88 p. Available from: http://www.hqontario.ca/evidence/evidence-process/episodes-of-care#community-copd
[19] Quality-Based Procedures: Clinical Handbook for Congestive Heart Failure. Health Quality Ontario & Ministry of Health and Long-Term Care. January 2013
[20] Health Quality Ontario; Ministry of Health and Long-Term Care. Quality-based procedures: clinical handbook for heart failure (acute and postacute). Toronto: Health Quality Ontario; 2015 February. 78 p. Available from: http://www.hqontario.ca/evidence/evidence-process/episodes-of-care#community-chf.

Total Joint Replacement[21]	Primary unilateral hip replacement	1.VA.53 (CCI)
	Primary unilateral knee replacement	1.VG.53 (CCI)
	Primary bilateral joint replacements	1.VA.53 or 1.VG.53 (CCI)

[21] Quality-Based Procedures: Clinical Handbook for Primary Hip and Knee Replacement. November 2013; pp. 1-95

APPENDIX C – Rehabilitative Care System Capacity Planning Framework Data Elements/Considerations by Source

Discharge Abstract Database
Socio-demographics of current rehab service recipients by population
Annual # of acute care admissions for conditions typically requiring rehabilitative care
Average/mean age of patients discharged from acute to each level of rehabilitative care/service per year
Percent of patients >65 years of age referred to each level of rehabilitative care/service per year
Description/profile of patients accessing rehabilitative care services outside of LHIN and the services they are accessing
ALC rates from acute to each level of rehabilitative care
Referral patterns/processes e.g. o % / diagnosis of patients referred to each level of rehabilitative care o Referral response times
Actual vs. Expected acute LOS for conditions typically requiring rehabilitative care*
Rehabilitative Care Patient Outcomes

*Refer to literature that indicates populations who benefit from rehabilitative care (cardiac cases, frail seniors, post-hospitalization deconditioned), RM&R Data and/or ALC data that indicates populations experiencing difficulty with access, patient stories/interviews etc. Also refer to Appendix 1 - QBP Handbook Cohort Definition and Patient Grouping Approach for definitions of QBP populations.

National Rehabilitation Reporting System
Utilization Rates - Rehab Cases/100,000
Average/mean age of patients admitted to each level of rehabilitative care/service per year
Socio-demographics of current rehab service recipients by population (e.g. hip fracture, stroke etc.)
Percent of patients >65 years of age admitted to each level of care/service per year
Percent of patients >65 years of age admitted to each level of rehabilitative care/service per year
Percentage of patients admitted to each level of rehabilitative care/service from outside of catchment area
Description/profile of patients accessing rehabilitative care services outside of LHIN and the services they are accessing
Average FIM Efficiency
Occupancy rates within each level of care
Profile of patients served within each level of rehabilitative care. E.g. 1. Place of residence (i.e. LTC, Community etc.) 2. Admission source to each level of rehabilitative care 3. Average admission FIM score 4. Average # of reported/recorded health conditions/comorbidities
# of patients served within each level of rehabilitative care
Intensity of services provided in each level of care (RIW)
Average # of patients repatriated to acute care from each level of rehabilitative care per month
Average # of ED visits from each level of care per month
Rates & Reasons for denial
Average travel time/distance of service from home of patient (by postal code)
Referral patterns/processes e.g. o % / diagnosis of patients referred to a bedded level of rehabilitative care o Referral response times
Patient Outcomes to be Considered Within NRS Include: • Average change in FIM score • Average LOS within each level of care (as compared to ELOS)

• Distribution of LOS by RPG • Patient Days/Year by RPG • Discharge disposition from each level of care • % discharged with service goals met (NRS) • Rate of readmission to acute care within 30 days of discharge from bedded level of rehabilitative care
Average LOS within each level of care (as compared to ELOS)
Distribution of LOS by RPG

Continuing Care Reporting System (CCRS)
CCC - Average/mean age of patients admitted to each level of rehabilitative care/service per year
CCC - Percent of patients >65 years of age admitted to each level of rehabilitative care/service per year
CCC - Percentage of patients admitted to each level of rehabilitative care/service from outside of catchment area
CCC - # of patients served within each level of rehabilitative care per year
CCC - Average LOS within each level of rehabilitative care (by age/diagnosis group)
Socio-demographics of current rehab service recipients by population (e.g. hip fracture, stroke etc.)
Intensity of rehabilitative care services provided in each level of care (RUG)
Average # of patients repatriated to acute care from each level of rehabilitative care per month
Occupancy rates within each level of rehabilitative care
Average # of ED visits from each level of rehabilitative care per month
Average travel time/distance of service from home of patient (by postal code)
Patient outcomes (e.g. change in ADL/mobility scores, discharge disposition etc.) by age/diagnosis group

CCAC/CHRIS
Socio-demographics of current rehab service recipients by population (e.g. hip fracture, stroke etc.)
Referral patterns/processes e.g. Percent/Number of patients, by diagnosis referred for in home rehabilitative care and associated referral response times, Time from referral to first rehabilitative care service, by discipline
Patient Outcomes

Health Service Providers (via survey or other means)
Socio-demographics of current rehab service recipients by population (e.g. hip fracture, stroke etc.)
PT/OT/SLP/Nursing etc. to bed ratios PT/OT/ SLP/Nursing etc. to patient ratios
Average therapy minutes received and/or provided per bed, per week in each level of rehabilitative care
Medical model of care e.g. # of planned weekly visits
Beds per rehabilitation candidate (Ideal if data available) OR Beds to incident population OR Beds per 100,000
Beds per 100,000 residents that are 75+
Configuration of rehabilitative care beds - number of sites, programs offered at each site etc.
Bed Equivalents based on 95% occupancy for each level of care
Distribution of LOS within each rehabilitative care program by age /program/diagnosis
Profile of patients served within each level of rehabilitative care. E.g. 1. Place of residence (i.e. LTC, Community etc.) 2. Admission source to each level of rehabilitative care

3. Average admission functional score / level 4. Average # of reported/recorded health conditions/comorbidities
OP/Amb & Community - Location of programs/services
OP/AMB - FTE/volume of patients
OP/Amb - Population distribution relative to service availability
OP/AMB & In-home Care - # of visits/ attendances (average/ median) per health profession functional centre for all health profession functional centres received by each patient within the episode of care
OP/AMB & In-home Care • # who received physiotherapy, average total number of PT minutes per episode of care • # who received social work and average total number of SW minutes per episode of care • # who received SLP, average total number of SLP minutes per episode of care • # who received occupational therapy, average total number of SLP minutes per episode of care • Average length of each episode of care • Average total cost for an episode of care to treat each patient by patient population/diagnosis group
OP/AMB & In-home Care - Total # of minutes being provided to patients per episode of care
In-home Care - Number of contracted home care allied FTE per capita
In-home Care - Services delivered by condition/ diagnosis: • # who received nursing and # of visits per case • # who received physiotherapy and number of visits per case • # who received social work and number of visits per case • # who received SLP and number of visits per case • # who received personal services and number of hours per case • # who received occupational therapy and number of visits per case
CCAC - Allied health home care hours/costs per unit of service
LTCH - number of PT/OT/SLP/RN Full-Time-Equivalent (FTE) and their support staff (including all purchased services)
LTCH - Number of Physiotherapy minutes per resident
LTCH - Duration and frequency of classes, number of participants
CCC & LTCH – proportion of patients within each level of rehabilitative care receiving rehabilitative care services
Rates & reasons for denial
Average travel time/distance of rehabilitative care service from home of patient (by postal code)
Wait times to access rehabilitative care services and reason for wait (i.e. operational versus supply/demand pressures)
Referral patterns/processes e.g. • %, number and/or diagnosis of patients referred to rehabilitative care • Referral response times
Describe transportation options (public and accessible) that are available to support family/caregivers to attend/visit
Cost to deliver service

Qualitative (e.g. by survey and/or stakeholder consultation) & Potential Multiple Data Set Analysis
Current trajectory of care
Comparison of admission/discharge criteria across sites, programs and/or populations
Critical mass – Do volumes exist (by population) to support a local service? If not, is there timely, streamlined access to regional services?
Population distribution relative to service availability e.g. o Proximity of beds across the region by the patient population

o Services matched to patient need (e.g. designation under French Language Services Act)
Correlation of ALC to occupancy (i.e. process versus access issues?)
Describe transportation options (public and accessible) that are available to support family/caregivers to attend/visit
Contribution of each rehabilitative care program/service to other system services (e.g. flow, care integration etc.)
Best practices/trends
Potential/planned partner service changes
Desired/ideal trajectory of care
Based on available best practice literature, anticipated need and/or current performance describe the ideal future state with respect to: o Staff to patient/bed ratios as per provincial definitions framework and best practices o Bed to population ratios (e.g. beds per 100,000) o PT/OT/Therapy Assistant /SLP/Nursing etc. to bed/ patient ratios o Medical model of care (i.e. # of planned weekly visits) o Number/location of outpatient /ambulatory services o Number of contracted home care allied FTE per capita o (LTCH) Number and hours of Physiotherapist Full-Time-Equivalent (FTE) and their support staff (including all purchased services) o Length of stay/ELOS (by RPG) o Volume of patients served within each level of care (by RPG) o Occupancy rates within each level of care o Acute ALC rates to each level of rehabilitative care o ALC rates within each level of rehabilitative care o Allied health home care hours/ costs per unit of service o Allied health outpatient hours/ costs per unit of service o LTCH ▪ Number of Physiotherapy minutes per resident ▪ Duration and frequency of classes, number of participants ▪ Proportion of patients receiving rehabilitative care services o Intensity of rehabilitative care o Market analysis and ideal market share o Required critical mass as per best practice o Wait times to regional programs, where critical mass does not exist o Equalized service availability (i.e. distance from home) relative to population distribution o Streamlined referral patterns/ processes o Wait times for all levels of rehabilitative care o Equalized service availability / Rehabilitative care service distribution relative to population o Streamlined referral patterns/processes o Patient outcomes (e.g. patient disposition for all rehab populations including those designated ALC). o Cost to deliver service o Contribution of each rehabilitative care program/service to other system services (e.g. flow, care integration etc.)
Consider alternate/innovative service delivery model/settings
Consider opportunities for standardization, automation, computerization and forcing functions maximize efficiency/utilization
Describe ideal transportation options (public and accessible) required to support patients/caregivers to access services
Describe a streamlined process to support patients with functional progression or maintenance goals who are

transitioning from an acute or formal rehabilitative care setting to a community-based setting who are transitioning across the rehabilitative care system
In consideration of 'Reasons for Denial', what additional services are required to support access for populations currently not being served?
# of Allied Health Professionals (PT/OT/SLP/RN) per 100,000 (per LHIN)
Location of rehabilitative care services relative to referral source and residence of patient

Rehabilitative Care Alliance (www.rehabcarealliance.ca)
Optimize alignment of resources / services with provincial directions (e.g. RCA Definitions Framework, Assess and Restore Guideline etc.) ○ Determine the optimal resource mix and capacity requirements for delivering A&R within their boundaries, with the goal of providing the most appropriate interventions in the most cost-effective manner possible ○ Is there benefit to designating a portion of rehab/CCC beds for direct community access as per the A&R guideline? Rehabilitative Care Alliance Outpatient/Ambulatory Minimum Data Set

Assess and Restore Guideline - http://www.health.gov.on.ca/en/pro/programs/assessrestore/docs/ar_guideline.pdf) (Active as of January 15, 2014)
Optimize alignment of resources / services with provincial directions (e.g. RCA Definitions Framework, Assess and Restore Guideline etc.) ○ Determine the optimal resource mix and capacity requirements for delivering A&R within their boundaries, with the goal of providing the most appropriate interventions in the most cost-effective manner possible ○ Is there benefit to designating a portion of rehab/CCC beds for direct community access as per the A&R guideline?

Public Health Ontario - http://www.publichealthontario.ca/en/DataAndAnalytics/Snapshots/Pages/Chronic-Disease-Hospitalization.aspx (Active as of January 15, 2015)
Annual prevalence/incidence by condition/population

Statscan - http://www.statcan.gc.ca/tables-tableaux/sum-som/l01/ind01/l3_3867_3433-eng.htm?hili_demo05 (Active as of January 15, 2015)
Population projections
Population-level incidence & prevalence rates

Ministry of Finance - http://www.fin.gov.on.ca/en/economy/demographics/projections/ (Active as of January 15, 2015)
Population projections

Other Data Sources

Consideration/Data Element	Source
# of Physiatrist per 100,000 (per LHIN) # of Geriatricians per 100,000 (per LHIN)	Ontario Active Physician Registry
# of Allied Health Professionals (PT/OT/SLP/RN) per 100,000 (per LHIN)	Respective Professional Colleges
Community Physiotherapy Clinics - volumes, FTE, wait list, patient profiles/ diagnosis	MOHLTC
Duration and frequency of Ministry exercise classes, number of participants.	MOHLTC LHIN
Duration and frequency of falls prevention classes, number of participants.	MOHLTC LHIN
Rate of readmission to acute within 30 days of discharge from bedded level of rehabilitative care	Integrated Decision Support (where available)
Rate of readmission to acute care within 30 days of discharge from acute care (for conditions that are expected to require post-acute rehabilitative care)	
LHIN Level ALC Rates	Access to Care
Incidence of rehab need by condition (e.g. number of stroke patients that are known to require each level of rehabilitative care based on stroke severity compared to actual numbers of patients served)	Relevant best practice literature and/or QBP Handbooks (where available)
Actual Cost Per Weighted Case vs. Expected Cost Per Weighted Case (Note: This measure is only relevant for hospitals under HBAM	Health Data Branch web portal (hsimi.on.ca) under HSFR
Direct vs. Indirect Costs to deliver service	

Appendix D - Glossary of ACRONYMS

Acronym	Definition	Acronym	Definition
CP&SE	Capacity Planning & System Evaluation	**OP/AMB**	Outpatient/ Ambulatory
RCA	Rehabilitative Care Alliance	**RM&R**	Resource Matching and Referral
QBP	Quality Based Procedures	**TBD**	To Be Determined
HSPs	Health Service Providers	**A&R**	Assess and Restore
LHINs	Local Health Integration	**LOS**	Length of Stay
LTCH	Long Term Care Home	**ELOS**	Estimated Length of Stay
OHA	Ontario Hospital Association	**RUG**	Resource Utilization Group
CCC	Complex Continuing Care	**HR**	Human Resources
ALC	Alternate Level of Care	**FIM**	Functional Independence Measure
MDS	Minimum Data Set	**ED**	Emergency Department
LTC	Long Term Care	**FTE**	Full Time Equivalent
CCAC	Community Care Access Centre	**SW**	Social Work
PT	Physiotherapy	**OT**	Occupational Therapy
SLP	Speech Language Pathology	**RCA**	Rehabilitative Care Alliance
RIW	Resource In	**RPG**	Rehab Patient Group
RAI-MDS 2.0	Resident Assessment Instrument – Minimum Data Set 2.0	**NRS**	National Rehabilitation Reporting System
FLSA	French Language Services Act		